Plattsburgh
primary care
primarycare
159 Margaret Street
Suite 103
Plattsburgh, NY 12901

Pediatric History Questionnaire

Center:

Name:

DOB:

MR #

PATIENT INFORMATION

Date_____ Medical Record #_____

Name_____ Birth Date_____ Age____

Address_____

Telephone _____

	Name	Birth Date	Occupation	Healthy?
Father				
Mother				
Brothers & Sisters				
Others living in household				

Are natural parents living together? Yes ☐ No ☐

Birth weight_____ Length_____

Please circle correct response:

Was pregnancy normal or difficult?	Normal	Difficult
Was delivery normal or difficult?	Normal	Difficult
Was the baby full-term?	Yes	No
Did baby have any problems in nursery?	No	Yes
Any problem during the first month of life?	No	Yes

Development:

At what age did your child:

Sit up without support	_____	months
Walk alone	_____	months
Talk (two words together)	_____	months
Become bladder trained	_____	
Become bowel trained	_____	
If in school, present grade	_____	

Are there any problems that concern you about this child now? _____

_____

_____

List all hospitalizations, major illnesses, accidents, and broken bones

Date	Child's Age	Name of Hospital	Reason for Hospitalization

Any allergy to food or medication? Yes ☐ No ☐

If yes, please list them _____

_____

List medications child is presently taking, including vitamins and fluoride _____

_____

Review of Systems

Indicate which of the following conditions or problems this child has ever had:

( ) Skin trouble
( ) Eye problems
( ) Frequent ear infections
( ) Difficulty hearing
( ) Frequent nose bleeds
( ) Frequent sore throats
( ) Pneumonia
( ) Any other lung problems
( ) Heart murmur
( ) Jaundice
( ) Frequent stomach aches
( ) Frequent diarrhea
( ) Frequent constipation
( ) Black stool
( ) Kidney or bladder infection
( ) Painful urination
( ) Bedwetting
( ) Painful periods
( ) Anemia
( ) Joint aches or pain
( ) Loss of consciousness
( ) Seizures
( ) Frequent headaches
( ) Behavioral problems

Other _____
_____
_____

( ) Rheumatic Fever
( ) Measles
( ) Chicken pox
( ) Mumps
( ) Rubella

Social History

What does child do in spare time? _____
How many hours a day does child watch TV? _____
Indicate any financial, interpersonal, or family problems you are worried about.
_____
How is he/she doing in school? _____
Does he/she have good friends? _____

Family History — Check any of the following diseases which relatives (including aunts, uncles, cousins, grandparents) have:

Eczema _____
Seizure disorder _____
Tuberculosis _____
Hayfever _____
Asthma _____
High blood pressure _____
Heart attack, stroke (under 55 years of age) _____
Diabetes _____
Obesity _____
High cholesterol or triglycerides _____
Anemia or blood problems _____
Alcoholism _____
Kidney disease _____
Cystic fibrosis _____
Cancer _____
Mental retardation _____
Birth defects _____
Psychiatric problems _____
Death before 50 years of age, other than accident _____

_____ _____
Reviewed by: (MD, NP, PA) Signature
Date